Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TEXAS HEALTH

Respondent Name
TPCIGA for FREESTONE INSURANCE COMPANY

MFDR Tracking Number
M4-14-0228-01

Carrier's Austin Representative
Box Number 50

MFDR Date Received
September 23, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "As of today we have yet to receive payment and/or EOB. The claim was timely filed per the attached. . . . It is our position that Dallas National Insurance [now Freestone Insurance Company, an impaired carrier, here represented by the Texas Property & Casualty Insurance Guaranty Association (TPCIGA)] has established an unfair and unreasonable time frame in paying for the services that were medically necessary and rendered . . ."

Amount in Dispute: $7,000.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not submit a response for consideration in this review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 14, 2013	Neuropsychological testing, procedure code 96118	$7,000.00	$3,006.40

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
3. Neither party submitted copies of explanations of benefits (EOBs) detailing the insurance carrier's final action regarding the services in dispute.
4. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on October 21, 2013. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

Issues

1. Did the requestor provide documentation to support insurance carrier receipt of the request for an EOB?
2. Did the requestor submit copies of the EOB(s) as required by Division rule?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.307(c)(2)(K) requires that the request shall include "a paper copy of each explanation of benefits (EOB) related to the dispute as originally submitted to the health care provider . . . or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB." Review of the submitted documentation finds that the request does not include copies of any EOBs for the disputed services; however, the requestor has provided a copy of a facsimile transmission report establishing convincing evidence of insurance carrier receipt of the request for an EOB. The Division concludes that the requestor has met the requirements of §133.307(c)(2)(K).
2. 28 Texas Administrative Code §133.307(d)(2) requires that "Upon receipt of the request, the respondent shall provide any missing information not provided by the requestor and known to the respondent. The respondent shall also provide the following information and records: . . . (B) a paper copy of all initial and appeal EOBs related to the dispute, as originally submitted to the health care provider in accordance with this chapter, related to the health care in dispute not submitted by the requestor or a statement certifying that the respondent did not receive the health care provider's disputed billing prior to the dispute request." The insurance carrier did not submit a response for consideration in this review. The insurance carrier did not submit copies of any EOBs regarding the services in dispute. Review of the submitted information finds no statement certifying that the respondent did not receive the health care provider's disputed billing. The Division therefore concludes that the respondent has not met the requirements of §133.307(d)(2)(B).
3. The insurance carrier has presented no defenses or reasons for denial of payment for the disputed services. Reimbursement is therefore considered per applicable Division rules and fee guidelines. This dispute relates to professional medical services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.203(c), which requires that "To determine the MAR [Maximum Allowable Reimbursement] for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83 . . . (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year." The applicable Division conversion factor for calendar year 2013 is $55.30. The services were rendered in Dallas, Texas. Reimbursement is calculated as follows:

   - Procedure code 96118, service date February 14, 2013, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 1.86 multiplied by the geographic practice cost index (GPCI) for work of 1.009 is 1.87674. The practice expense (PE) RVU of 0.77 multiplied by the PE GPCI of 1.017 is 0.78309. The malpractice RVU of 0.07 multiplied by the malpractice GPCI of 0.834 is 0.05838. The sum of 2.71821 is multiplied by the Division conversion factor of $55.30 for a MAR of $150.32 at 20 units is $3,006.40.

4. The total allowable reimbursement for the services in dispute is $3,006.40. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $3,006.40. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $3,006.40.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $3,006.40 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	November 25, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.